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FALLS CHURCH
COMMUNITY SERVICES BOARD

Report of the Mental Health Day Support Work Group
RECOVERY, EMPLOYMENT AND REHABILITATION SERVICES

Mental Health Day Support Work Group Members

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RECOVERY, EMPLOYMENT & REHABILITATION SERVICES:

Introduction

The Process: A bit more than a year ago, a broadly constituted design group was convened to examine the array of mental health day program services available for consumers served by the Fairfax-Falls Church Community Services Board. The Design Group was charged with conducting a comprehensive needs assessment of key stakeholders and, after gathering this important information, to construct recommendations for re-design of some existing programs and, where necessary, adding new ones. This set of documents represents the work of the Design Group. While the documents offer a fair bit of design detail, much of what the team proposes also represents a work in progress. This is a very deliberate plan inasmuch as the designers expect programs to continually monitor key issues like outcome, capacity, length of stay, cost, location and – in a very dynamic way – reallocate resources across the network of services as needs emerge or change. Any program set in stone soon outlives its usefulness to people it intends to serve. There are also other fluid factors, such as available funding streams, that must inform and impact an array of services such as these. So what follows are a beginning set of recommendations for programmatic design, with the expectation that periodic further change will occur as it is supported by the ongoing data which will be collected.

It is important to note that the Design Group began with some shared values and visions.

The Recovery Model Philosophy: The Recovery Model is a main underpinning of all that follows. Recovery is the process by which people rebuild and further develop the important elements of their lives – meaning, social relationships, work, recreation and activities of the spirit. It is the development of a valued role – a place to fit – within the community and within oneself.

It is not a "cure." It is not the end of the road. It is a process of adjusting one's attitudes, beliefs, directions, roles and visions in life, in order to establish a positive self-image that is hopeful, involved and self-guided. It is connecting to and bringing out the person beyond the illness, recognizing that the label of an illness can in no way capture the richness and complexity of the personhood in every human identity.

Recovery as a treatment approach has certain characteristics:

- It focuses on strengths
- It treats people with respect
- It assumes that people can arrive at valid decisions and solutions
- In that regard, it trusts the resourcefulness of consumers
- It develops trusting, equal relationships and partnerships
- It communicates respectfully
- It understands discrimination and stigma and their impact
- It acknowledges cultural differences and ways these differences may impact the course and nature of recovery
- It develops and blends individual, family and cultural perspectives in living
- It assumes hope and success

Recovery is happening when people can live well in the presence or absence of mental illness.

The Principles of Design: As the design group worked, it focused on attempting to lay out a **network** of services that would address some of the key conceptual issues that stakeholders have repeatedly raised and articulated.

- **Collaboration.** All of programs must talk with each other and collaborate.
- **Problem Solving.** System barriers to services will be removed and problem-solving approaches will be the norm.
- **Known and Coherent Resources.** There must be a central, comprehensive inventory of available network resources.
- **Communication.** Descriptions, entry criteria and estimated openings for each program should be communicated to consumers, families, referrers, advocates and staff.
- **Stakeholder Involvement and Voice.** All stakeholders – but especially consumers – must be actively included, involved and incorporated in the process. This must take the form of day-to-day treatment decisions, as well as longer-term programmatic input.

A Brief Overview of the Proposed Programs: ***The elements about to be described do not stand alone. There are six principal programs in this network of services but they are linked and bridged in a number of important ways. First, here is a thumbnail on the program areas. Following that will be a description of the linkages and bridges.***

- **Consumer Run Drop-in Centers.** Ideally there should be three sites, one each in north, central and south county. The centers could offer a variety of supports for employment, social connectedness, symptoms, dual-diagnosis issues, and recreation. They would be a place for consumers to engage with one another. A warmline would be established. Drop-in centers provide consumer choice and control. They also offer important peer-driven support, no matter what level of need or interest is brought to the site by any given consumer. While many consumers who use Drop-In services will also be connected with services offered by the Mental Health System, such a connection will not be a requisite.
- **Community Readiness and Support.** A program for consumers who have limited socialization skills, have difficulty establishing and maintaining relationships and who tend to get overwhelmed by the large treatment groups. They require high monitoring, low demands, flexible support, crisis intervention, small groups, dual diagnosis services and employment supports. While they are not ready for more engaged psychosocial day support functions, the goal would be movement into that level when and if possible.
- **Psychosocial Rehabilitation Services.** Activities include work units, psychoeducational groups, social activities and individual counseling. Program structure is flexible and can accommodate varying levels of participation. The focus of all program activities is to teach skills and provide supports for community integration, work readiness and independent living. Participants will be assessed and encouraged to develop readiness for change to promote recovery and wellness.
- **Employment Program:** Specializing in state-of-the-art vocational approaches, 80% of the Employment Program will focus on job choosing, job getting, job keeping, job coaching, and long term wage employment. However, since the program is designed for consumers with a mental disability, the provider must also focus on activities that maintain and sustain psychiatric stability and maintenance. Therefore, 20% of the Employment Program may be used for activities such as; medication management,

relapse management, health care issues, substance abuse and co-occurring disorders, world of work and environmental stressors.

- **Focused Treatment:** Use of specialized staff with experience working with complex, chronically acute, high risk, low stability individuals, providing two-hour structured treatment modules, three days per week. Features include smaller staff to consumer ratio, high flexibility approaches, crisis stabilization.
- **Intensive Recovery Services:** A comprehensive program to divert acutely symptomatic consumers from being hospitalized or for consumers who have just been discharged from an inpatient unit, but who require further stabilization. Four to six weeks up to a maximum of three months (exceptions in fully staffed cases). Crisis stabilization, dual-diagnosis services, employment supports, psychoeducational, dialectical behavior therapy, a goal of maximizing successful transitions.

How Do the Pieces Fit Together? This mental health system, like many products of the Community Mental Health movement and its origins in the 1960's, has certain inertia from having done things the same way for a long time. Some of those programmatic approaches still have validity and you will recognize pieces of them in the proposed design. At the same time, there is a powerful movement to open the doors and windows of traditional systems and bring in the sunlight of the outside world and the voices and wisdom of all of its stakeholders.

The Design Group believes that the establishment of a **Community Involvement Partnership Council** is a critical starting point. In fact, the members of the Design Group felt so strongly about the underpinning of this partnership, that it recommends that the Council be established and go beyond involvement in the network of day support services outlined in this report and, rather, have input on all adult mental health services. This would include Day Support Services, Case Management Services, Emergency Services, Outpatient/Medication Services and Residential Services. Such a committee must be comprised of a full and diverse spectrum of stakeholders and have the opportunity to regularly speak its mind about the design and delivery of services. Moreover, this committee cannot remain complacent and assume that its own diversity is representative of all viewpoints. Some stakeholders, based upon prior experience – or cultural roots – will not readily come forward and volunteer for such a committee when it is formed. There must, then, be an active and reoccurring solicitation of community input if this committee and its process are to have any credibility or have the capacity to help the mental health system transform itself to meet evolving needs. This Council is one of the overarching linkages of the designs proposed here.

A second element that binds the pieces together is the centralized, standing **Integrated Referral and Transition Team.** This team is to be made up of high level representatives from a variety of key treatment programs. Members would have the authority to commit resources from their program areas, would become experts in available resources, disseminate information to referrers, and take a systemic rather than insular view of "best fit" for consumers. It would take pride in breaking down traditional programmatic barriers. A screening instrument will be developed to help placement decisions, but the group would also staff challenging cases that required brainstorming and group collaboration. Within this team are the seeds of the gradual transformation of the mental health system from one that is "slot" based to one that is more "needs" based. This team – with its finger on the pulse of evolving consumer needs and desires -

has the potential to recommend periodic redeployment of resources to meet these demands. Such redeployment might well even occur across agency/contractor lines.

Vocational and Prevocational Services are a third element that cross all six principal program areas. There is, as noted above, a discrete Employment program (which heavily emphasizes employment services with a psychosocial support underpinning). However, it is important to notice that there are vocational elements in each of the six major programs. This decision was made based upon an examination of a fair bit of research. What seems clear is that successful vocational programming is contingent upon the successful presence and integration of other key programming elements. For example, one study (Shankar & Collyer, International Journal of Psychosocial Rehabilitation, 2002) looked at competing vocational models and concluded that the presence of external and family social support networks often determined whether any vocational model could succeed. Such supports can be found in drop-in centers, in family integration work done as a piece of more structured programs, and in referrals to potential partners – such as NAMI-NV's 12-week family education program. The Design Group thought that the idea of networked and integrated services was so important, then, that there are vocational approaches and services in each of the six areas. Please see the attached overview paper entitled "Vocational/Prevocational Services" for an overview of the kinds of elements that are recommended.

Consumer Run Drop-in Centers were listed as one of the six major program areas because of design requirements. But these centers are also a linkage and are unlike any of the other main programs in that regard. That is, drop-in overarches all of the main programs – a consumer could participate in any of the other five programs and also use drop-in. So, for example, drop-in could provide a peer mentor for a consumer who has a good job, but needs some coaching on how to handle day-to-day works dilemmas – or it could be a starting place for someone who is unemployed and simply looking for information or encouragement. It is hard to overestimate the many useful functions that consumer-driven drop-in centers can provide. Among the most important is the opportunity to engage and assist individuals who feel disenfranchised by the formal mental health system but who may be willing to engage with, trust and learn from peers who have shared experiences and accrued wisdom.

There were other program elements that were considered so important by the Design Group that they are found in each program description. One of these is the **Support Network and Family Involvement** functions already noted in several contexts above. Another element involves **Crisis Intervention** services and the ways that they can be provided within programs, or with the support of the Mental Health System's Crisis Services Division. Coordinated **Case Management** will also obviously be a key component across all modalities.

One other overarching principle needs to be articulated and emphasized – and that is transitions. The Design Group envisions the array – the network - of programs connected by bridges built for movement and marked by flexibility and the capacity to move people within this system depending upon availabilities, consumer capabilities and consumer choices. The Integrated Referral and Transition Team will not only prize that philosophy, but be in a position to make it work.

Supporting and Explanatory Documents
Community Involvement Partnership Council
Recovery, Employment & Rehabilitation Services Grid
Vocational/Prevocational Services
Integrated Referral and Transition Team
Integrated Referral and Transition Team Diagram
Program: Consumer Run Drop-In Center
Program: Community Readiness and Support
Program: Psychosocial Rehabilitation
Program: Employment
Program: Focused Treatment
Program: Intensive Recovery Services

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The Community Involvement Partnership Council

Because we believe that:

1. ***Neither consumers nor family members experience Mental Health Services for Adults in segments;***
2. ***Comments on Mental Health Services for Adults cannot arbitrarily be limited to one program or division;***
3. ***Restraints on the scope of comments from stakeholders are both ineffective and experienced as a barrier to providing feedback;***
4. ***For Mental Health Services for Adults to be effective and of the highest quality, there must be substantial and ongoing consumer and family member input…***

We recommend that the
Community Involvement Committee/Recovery and Rehabilitation Support Services Advisory Committee
be renamed and rechartered as the
Community Involvement Partnership Council
with a focus on
Adult Mental Health Services.

Purpose:

- Enhance the quality of Adult Mental Health Services to include:
  - Day Support Services
  - Case Management Services
  - Emergency Services
  - Outpatient/Medication Services
  - Residential Services
- Provide a forum for feedback and communication
- Ensure consumer, family member, and community participation in planning, implementation, and monitoring of Adult Mental Health Services
- Maintain and enhance the collaborative, empowerment vision and the values in the recovery philosophy
- ***Note: The activities and the feedback made available through the Community Involvement Partnership Council do not replace the valuable information each Division obtains by reaching out to and listening to the specific individuals they serve.***

Membership:

- Members include consumers, family members, members of the community, CSB staff, nonprofit stakeholders, and other interested individuals.
- Members of the Community Involvement Partnership Council include members who are culturally representative of the community and people served by Adult Mental Health Services.
- A member of the Integrated Referral and Transition Team will be on the CIPC.

- The Chair of the CIPC is to become an Associate Member of the CSB Mental Health Subcommittee.
- There is to be no less than six consumers and four family members on the CIPC.
- Consumers and family members will be drawn from all Divisions serving adults in Mental Health Services.

Member Expectations:

- Recognizing the importance of knowledge about severe mental illness and the challenges that people with severe mental illness face in living in the community for members of the Council, training will be provided.
- Members need to be or become knowledgeable about Adult Mental Health Services.
- Information will be provided about the recovery philosophy as needed.
- The Council will need members who are good problem solvers with a positive attitude.
- Members listen to and seek to understand the perspective of all stakeholders.
- Members are actively involved in meetings.
- A commitment to regularly attend and participate in meetings will be required of all Council members.
- Membership in the Council involves a commitment of one year.

Community Involvement Partnership Council Activities:

- Advise service providers on how to make services relevant, culturally respectful, collaborative, and meaningful to consumers.
- Monitor ongoing program evaluation data.
- Participate in program assessment. Conduct surveys, interviews and/or focus groups for staff, consumers, and family members.
- Monitor consumer complaints.
- Examine areas needing improvement and make recommendations, review data in an ongoing quality improvement effort.
- Advocate for resources for the services and needed supports for consumers.
- Actively inform the Mental Health Subcommittee of the CSB of consumer concerns, issues, suggestions, etc.
- Build bridges to the community. Link with civic, business and other community groups.
- Build strategic support among key stakeholder groups.

Meetings:

- Frequency to be determined: meetings may be quarterly or monthly.
- Meetings will be held at times and in places that make family and consumer participation possible.
- All meetings will be held in handicap accessible facilities.

- Meetings will be open to public and will include the opportunity for comments from the public.

Officers/Structure of the Council:

- Chair
- Vice-Chair
- Secretary

Financial Considerations:

- Travel
- Meals/snacks
- Materials
- Staff support
- Day Care
- Stipends

Community Involvement Partnership Council Subcommittee Members:

Sharon Ekleberry, Chair
Renee Alberts
Ray Bridge
Mary Brown
Cynthia Evans
Joel McNair

RECOVERY, EMPLOYMENT & REHABILITATION SERVICES

	DROP IN CENTER	COMMUNITY READINESS AND SUPPORT	PSYCHOSOCIAL REHABILITATION	EMPLOYMENT SERVICES	INTENSIVE RECOVERY SERVICES	FOCUSED TREATMENT PROGRAM
PROGRAM PURPOSE	To provide a safe, supportive, non-demanding environment conducive for socialization, independent recovery and to make available resource information on recovery, co-occurring disorder, employment, etc.	To provide a therapeutic environment which promotes recovery and consumer participation in setting and achieving recovery goals.	To provide a structured rehabilitation program in which consumers learn skills and utilize resources to further goals of employment, school, social interaction and independent living. Services are provided in a community-setting promoting wellness and recovery.	To provide consumers the opportunity to reintegrate into the community by volunteering, working, and/or returning to school. The intent is to capitalize on the motivation and readiness of consumer to move forward in the recovery process.	To provide consumers acute, intensive focused treatment, including medication and medical services, to avoid inpatient hospitalization or as a step down from inpatient hospitalization.	To provide intensive focused treatment that concretely deals with immediate symptomatic behavior while seeking active, early prevention of inpatient hospitalization and the necessity of a "step down" from inpatient hospitalization to consumers who are more likely to succeed in this unique program than in a traditional group setting. Services are flexible and non-traditional. Manageable transitional steps are adapted to the consumer.
CONSUMER PROFILE	Consumers Seeking: • Peer support • Socialization • Employment information • Employment opportunities • Treatment information • Constructive use of time. And/Or • May not be interested or ready for structured programming • May have a co-occurring disorder	Consumers at early stage of recovery: • Experiencing active symptoms • Require flexible individual attention • Require high intensity services. • May have a co-occurring disorder • Seeking to learn socialization skills • Can especially benefit from specialized work on skills that help establish and maintain successful interpersonal relationships • More likely to flourish in a small group setting with some individualized attention • At risk for hospitalization • Homeless or at risk for homelessness • Difficulty recognizing personal danger	Consumers with a serious mental illness and significant functional impairment in major life activities. Need assistance and support with: • Community integration • Life skills • Work readiness • Independent community living skills And/Or • Need long term treatment and support • May have a co-occurring disorder • Do not require intensive supervision and monitoring • Able to benefit in group setting	Consumers with a serious mental illness who demonstrate cognitive abilities, stamina to develop and/or strengthen skills and a capacity to utilize resources to focus on an identified rehabilitation goal. Able to: • Formulate realistic goals • Have developed readiness to make behavioral changes • Promote wellness and community integration And/Or • In need of work adjustment training • May have a co-occurring disorder • Have a desire to learn new techniques to cope with symptom management	Consumers experiencing psychotic episodes, affective disorders, personality disorders, mixed diagnosis disorders, and/or personal crisis resulting in disruption of functioning. Able to: • Function as part of a large therapeutic community • Provide and receive feedback in group • Tolerate overt symptoms in others • Accept active substance abuse testing • Commit to and sustain participation in a daily treatment program • Benefit from intensive treatment for psychiatric stabilization • Participate in an active psychotherapy program. AND • Have a major mental illness diagnosis with or without co-occurring MH and SA diagnoses • Be at high risk for suicidal or harmful behavior	Consumers experiencing psychotic episodes, personality disorders, or mixed diagnosis disorders who are: • Diagnostically complex • At high risk for impulsive behavior • Mixed Axis or primary Axis II diagnoses including Borderline Personality Disorders. • In some cases, experiencing co-occurring neurological disorders • Potentially or known to be substance abusing • Possibly involved in extenuating forensic circumstances such as court ordered treatment • Previous difficulty in other MH or SA programs • Experiencing difficulty with interpersonal relationships • Ineffective or inappropriate socialization skills • Requiring intensive individual attention • Possibly presenting with complex medication issues

	DROP IN CENTER	COMMUNITY READINESS AND SUPPORT	PSYCHOSOCIAL REHABILITATION	EMPLOYMENT SERVICES	INTENSIVE RECOVERY SERVICES	FOCUSED TREATMENT PROGRAM
VOCATIONAL SERVICES	Employment training and support Computer training Ongoing support before, during and after employment obtained	Individual pre-vocational training and assessment	Assessment of work readiness Introduction to the world of work Pre-vocational training in work skills Support for all aspects of job choosing, getting and keeping Ongoing support by employment specialist either on or off site when employed.	Support for all aspects of job choosing, getting and keeping Ongoing support by employment specialist either on or off site when employed.	• Pre-vocational group co-run with DRS staff called "Assessing Readiness for Work"- also provides for individual assessment and training by DRS staff deployed to Intensive Recovery Services • Ongoing support in obtaining and maintaining voluntary and paid employment. • Liaison with employers who have client on disability leave awaiting readiness to return.	• Individual pre-vocational training and assessment • Outreach support to employers if the client has an existing job although these consumers are anticipated to have difficulty finding and maintaining any type of stable employment • Part of treatment focus, especially Dialetical Behavior Therapy, will be identifying new strategies and behaviors for approaching realistic employment possibilities.
LEVEL OF SUPERVISION AND MONITORING	Staff to monitor adherence to guidelines and procedures established by consumers and staff.	Staff available throughout the day with individual attention given as needed.	Consumers may come and go as they wish. Intensive supervision provided only during acute crisis.	Consumers may come and go as they wish. Intensive supervision provided only during acute crisis	Consumers are with staff through out the day. Attendance and participation are monitored. Absenteeism is monitored with follow up by primary therapist. Therapists meet with consumers individually on an as needed basis.	Consumers are monitored closely while they are in the program. The program has the potential ability to transport consumers to and from program when warranted. Individual work may be done through outreach and home visits if additional program time is available.
STAFF TO CLIENT RATIO	1:30	1:6	1:20	1:15	1:5	1:6
CAPACITY	90 (3 sites)	12 (1 site)	167 (3 sites)		44 (2 sites)	20 (2 sites)

Vocational/Pre-Vocational Services

Description:

An array of vocational/pre-vocational services, that provides employment resources, education and training, to help consumers who wish to acquire competitive or paid employment. This range of vocational/pre-vocational services is incorporated into all levels of the Recovery, Employment and Rehabilitation Day Support Services.

Purpose:

The objectives to be met include: assessment of employment's impact on benefits; providing opportunities for consumers to find and maintain meaningful and satisfying employment; assisting in the learning of employment-related skills that will allow each consumer to maximize his/her independence in the community; planning for career advancement; and empowering consumers to take responsibility for their lives, make informed decisions, and achieve self-sufficiency.

Eligibility and Exclusionary Criteria:

All consumers with a mental illness, attending one of the Recovery, Employment and Rehabilitation Day Support Services, who state a desire to be employed and demonstrate a willingness to work towards achieving employment outcomes. Consumers who state they are not interested in employment, or do not demonstrate the willingness to work towards achieving employment outcomes would not be appropriate for this service at that point in time. Either of these factors may change over time; therefore, frequent reconsideration and reassessment is critical. Co-occurring mental illness and substance abuse create additional barriers to successful outcomes but are not exclusionary criteria.

Consumer Profile:

Consumers with a mental illness or co-occurring disorder who state a desire to be employed and demonstrate a willingness to work towards achieving employment outcomes. Cognitive ability may vary, as may range, presence and severity of symptoms.

Services Provided:

We expect 35% of the consumers attending each of the Recovery, Employment and Rehabilitation program will be referred to an Employment Specialist working in the Employment Services area.

While these consumers are attending one of the Recovery, Employment and Rehabilitation Day Support program, the following services will be available to address specific employment skills needed to achieve positive outcomes:

Pre-Vocational Training

- Work Adjustment Training
- Situational Assessments
- Transitional employment positions (TEP)
- Work-oriented programming
- Assessment of work readiness

Job Choosing:

- Identifying current and needed skills, interests, values, and resources
- Using interest inventories, situational assessments, and work adjustment training
- Developing an appropriate employment goal
- Coaching to help find good job placement match
- Benefits planning assistance

Job Getting:

- Writing resumes and cover letters
- Practicing interview skills
- Finding job leads and filling out job applications
- Organizing job-seeking activities

Job Keeping/Job Coaching:

- Filling out new hire paperwork
- Organizing and reinforcing your training on the job
- Managing social security benefits
- Communicating with coworkers
- Job skills training

Long-Term Employment Support Services:

- Getting along with co-workers
- Problem-solving workplace conflict
- Planning for career advancement
- Individual and/or group follow-along
- Liaison and advocacy with employer as desired and indicated
- On and off-site job support as desired and indicated

Employer Education:

- Education and Training
- Management Issues
- Disability Management services to insure reasonable accommodations

Capacity, Length Of stay, Termination, Transition, Discharge, Levering Of Supervision, Staff To Consumer Ratio, How To Apply and Admission Procedures:

These are the same as they are for each Recovery, Employment and Rehabilitation program.

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Location:

Vocational/Pre-Vocational Services are located at each site where a Recovery, Employment and Rehabilitation program is offered thorough out the county.

Employment opportunities may be located throughout the region for the 35% of the consumers referred to the Employment Specialist. Location is based upon consumer's ability to get to the workplace. The location of employment supports may be: on the job site; in the community; or at a provider's office. The location of both the employment site and site for provision of employment supports is highly individualized and based upon consumer preference and need.

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Integrated Referral and Transition Team

Background:

When Stakeholders were surveyed last year about significant problems with access to day support network of services, several themes came up repeatedly:

1. We heard that programs neither talked with one another nor cooperated in sharing and coordinating resources.
2. We heard that no one knew what resources existed, making it impossible to effectively inform consumers of options or find treatment matches likely to succeed.
3. We heard that there were many built-in barriers to services and no central responsibility for fixing those problems at a systems level.

Why Make Changes?

Changes are being made in order to accomplish the following:

1. Level the playing field and give all consumers equal access
2. Maximize utilization
3. Improve communication among service providers
4. Increase the capacity of the number of consumers being served
5. Expand network of services in an effort to provide some degree of services to all consumers
6. Establish a need base system to prioritize consumers according to greatest need
7. Direct and re-direct resources to population with greatest needs
8. Increase awareness of all day support services available system-wide
9. Eliminate barriers to services

What Will Be Different or New?

1. Create a unified referral process that is implemented and utilized system-wide
2. Consumer access to services countywide with programs located geographically across the county
3. Comprehensive Drop In Centers substantially consumer operated
4. Community Readiness and Support program available to all consumers
5. Two distinct Psychosocial programs with different focus
6. Focus Treatment program for consumers not able or willing to benefit from traditional Partial Hospitalization program
7. High emphasis on employment and training in each of the programs in the network of services
8. Direct consumer access to one program (drop-in) - and consumer input and choice in program selection in other five programs
9. Increase the total number of consumers receiving day support services

How Will the Integrated Referral and Transition Process Work?

Establishing a central, high-level referral and transition team will facilitate a comprehensive, unified, systemic approach to treatment. The Team will work together on a regular basis to help match consumers with a day support network of programs that best fit their needs and preferences and facilitate smooth transitions and bridging as part of recovery movement. As an aid to referral and placement, a screening instrument will be developed, based upon the parameters of major program areas and the kinds of consumer profiles that each program best addresses.

This Team offers a number of significant benefits that directly address the concerns raised by our stakeholders.

- Its membership is deliberately set at a level that ensures that decision-makers are at the table and can make commitments on behalf of their programs.
- It establishes a central repository and listing of available day continuum resources, remedying the historical problem of fragmented resource knowledge.
- Since all key treatment providers are represented, effective working relationships will be established.
- With the same group of managers working together, creative systemic solutions and problem solving approaches will develop over time.
- The Team provides a monitoring and feedback loop from a systems level perspective. When it sees barriers and problems in the process, it will develop solutions. This makes the process dynamic and ensures that the array of services that are being developed under the Recovery and Rehabilitation Support Services model can and will change to meet evolving needs.
- The Team will, to the best of its ability, move from a "slot" based system and move toward a "need" based system.
- Team will initially meet weekly and will adjust frequency as demand dictates.

See diagram of the Integrated Referral and Transition Team attached (I.R. &T.T.).

Will This Integrated Referral and Transition Process Impede or Delay Admissions?

We do not expect any delay in admissions. Our goal will continue to be 100% utilization of all services. We are aware of the fact that services may not be immediately available for all referrals due to limited capacity, therefore a waiting list will be established for each service area with priority being given to consumers with the greatest needs. Each program will have an approved list of consumers to select from for each vacancy. It is expected that programs will be proactive and make plans to fill each anticipated vacancy prior to a given consumer's graduation or transitioning from the program.

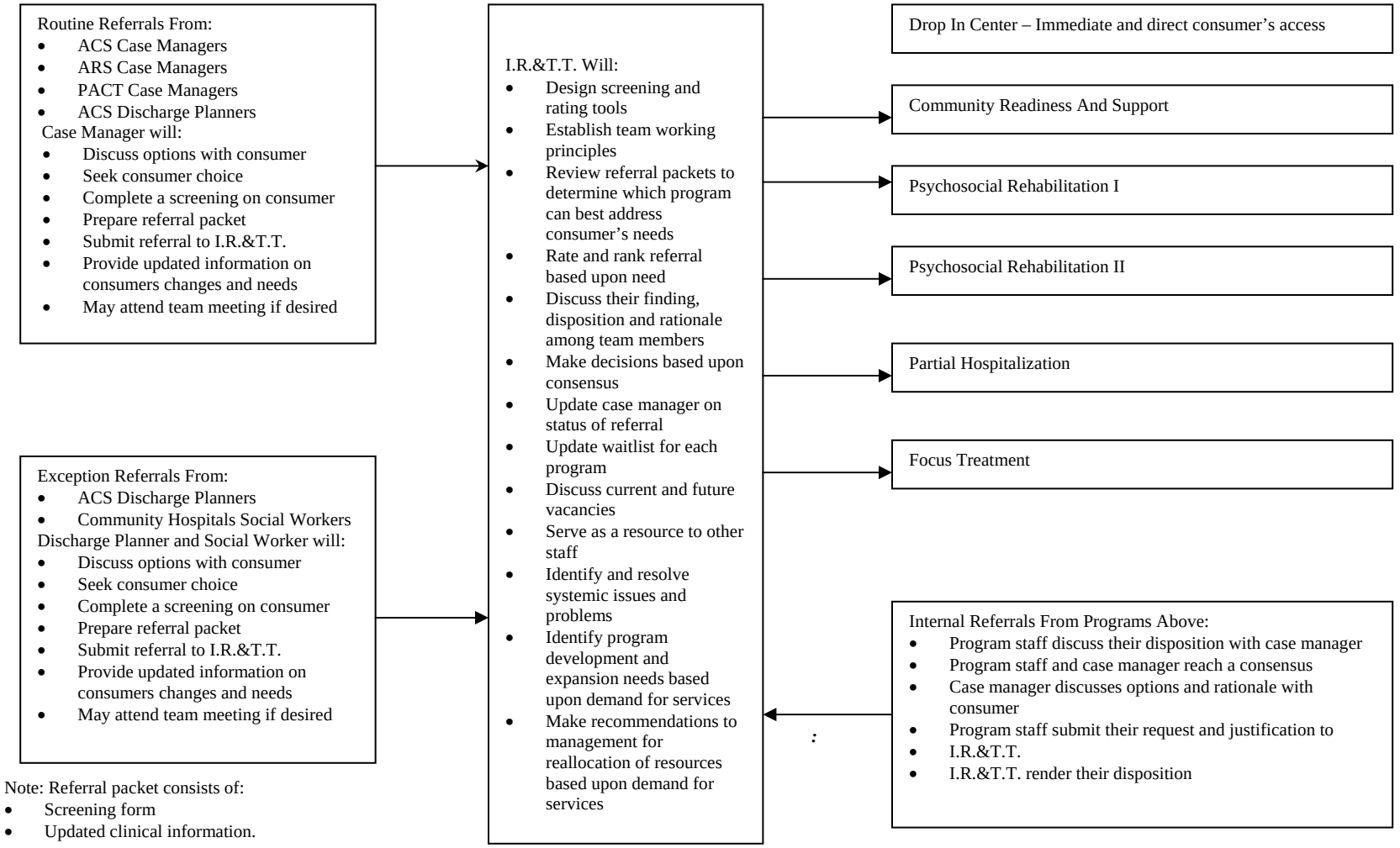
How Will Exceptions or Immediate Access Work?

Each program in the network of services will establish a capacity, which is the number of consumers they are able to serve in the program. Programs will be expected to operate with enrollment at capacity. However, all programs will also be expected to take in up to three consumers over capacity temporarily to accommodate consumers needing immediate placement. Often these will be consumers being discharged from hospitals and institutions or on the verge of being hospitalized and clinically not able to manage without a day support program.

Composition:

- Adult Community Services Mental Health Manager
- Adult Residential Services Mental Health Manager
- Partial Hospitalization Services Mental Health Manager
- Crisis Care Mental Health Manager
- A Manager from each day continuum contractor.
- Consumer Representative(s) from Drop-in Center(s)
- Invited specialists as the need arises.
- Rotating chair among members of Team.

INTEGRATED REFERRAL AND TRANSITION TEAM DIAGRAM (I.R.&T.T.)



CONSUMER RUN DROP IN CENTER

W hy A Consumer Run Drop In Center

- Assist in achieving the goal of consumer empowerment
- Provides the opportunity to plan an impressive array of services to participate in
- Provides a means to improve their quality of life
- Provides a means to seek peer support
- Provides an opportunity to participate in social activities
- Provides a means to seek help in obtaining services
- Provides a place to relax and have fun without demands
- Provides an opportunity to learn practical lesson about planning, budgeting and working
- Provide users an opportunity to develop a sense of responsibility and self-worth
- Provides a means to stress personal values of recovery
- Provides a direct and immediate access to program without barriers
- Provides a means to provide services to a large number of consumers
- Provides a mean for services to be completely voluntary
- Provides an effective alternative to expensive traditional mental health services

W hat Is A Consumer Run Drop In Center

A service operated and managed by consumers with a mental illness for other consumers with a mental illness in a facility that can accommodate a significant number of people.

Purpose

To provide a safe, supportive, non-demanding environment that is conductive for socialization, information sharing and encourages engagement for those not yet ready for, or interested in, structured recovery programming. Also provide the same "non-program" support for those choosing and capable of following a more independent approach to recovery.

Management And Operation

Individuals with a mental illness will primarily carry out, the day to day management and operations of the program. At least 50% of the staff must identify themselves as having a mental illness. At-least 75% of the Board of Directors must identify themselves as having a mental illness. Board of Directors will be responsible for establishing rules and guidelines for program's operations and will be actively involved with the hiring of staff.

Users Involvement

Consumer involvement is clearly paramount. Consumer users of the service will decide themselves how (i.e. how often and for how long) they want to utilize these services. Specific input from consumers of the service will be solicited through suggestion boxes, community meetings and individual input. Consumers/staff of the program will meet to develop a mechanism such as a Board or Committee to establish guidelines and

procedures, etc. Additional opportunities for consumer input and involvement will be explored as services evolve.

Activities And Services

An array of services may be available at a Drop In Center. The activities are determined based upon the particulars wishes and needs of the consumers involved. Some examples of such services are:

- Self help groups
- Recovery activities
- Co-occurring disorder groups
- Socials and parties
- Information and referral resource
- Educational activities
- Recreational activities
- Employment assistance and information
- Dual recovery anonymous
- Warm line
- Access to phone system
- Speakers bureaus
- Advocacy
- Computer access and training
- Snack bar or concession stand

Consumers will be permitted to implement everything they enact as long as it is ethical, legal and financially possible.

Eligibility and Exclusionary Criteria:

Consumers 18 years of age or older with a psychiatric disability are eligible for services.

Consumers who display or exhibit aggressive, predatory or abusive behavior while in attendance at drop-in centers will be excluded from service and asked to leave the drop-in site.

Staff overseeing drop-in services, board of directors or appointed committees in conjunction with collateral providers, as appropriate, will determine when an individual use of services would pose a threat to themselves or other consumers. Board and members will work to develop a process or set of guidelines to be used when consumers who are asked to leave would like to be readmitted to the program.

Consumer Profile:

Drop-in services would serve both those individuals with serious psychiatric disability who are not interested in, or ready for, active participation in structured programming AND those individuals who desire a base of operations or “touch point” from which to receive ongoing peer support as they independently work toward their own recovery.

How to Apply:

Direct access, there is no application process. Consumers may be asked to provide some basic registration information for safety purposes.

Admission Procedures:

Direct access for those desired to participate.

Senior Drop In Center staff may sit on the Referral and Placement Team, to insure a shared understanding of all program components by all providers.

Support Network and Family Involvement:

Staff and volunteers will be aware of the array of services available to families of individuals with psychiatric disabilities. Brochures and other information pertaining to these resources will be prominently displayed and readily available to those who desire them.

Drop In Center staff or board member may sit on The Community Involvement Partnership Council.

Crisis Intervention/Management:

The Drop In Center staff will need to be in a position to address crisis intervention issues in order to maximize safety and reduce risk. Therefore, we will make available a provision for comprehensive training and supervision to drop-in center staff and volunteers. Training and consultation will be available off-site. Additional risk reduction is achieved though the development of specific crisis intervention and emergency policies. These policies will articulate specific relationships between the drop-in center, the local police and CSB/MH Emergency Services. Policies will outline coordinated procedures for responding to critical situations.

Capacity:

Capacity will be determined based upon the size of facility being used and number of staff hired. We will maintain a staff to consumer ratio of 1:30. Special services will maintain these ratios; Recreational services 1:15, Warm Line, two telephone lines available staffed by two trained staff. DRA , 1 group leader per 15 group members. Employment Services: staffing capacity on-site TBD. The staff listed are direct service staff and oversee operations of the program. If specific services are to be offered at the site such as employment services or computer training, a contracted vendor or staff person will come on one specific day per week for that activity only- they will not be a part of the hired staff performing day to day operations.

Location:

North/West, South/East and Central sections of the county. Sites may be located with or near existing contract sites. Needs assessment will need to be done to determine sites where service is most needed and most logical in terms of transportation, etc.

Length of Stay:

No limit, based on consumer choice.

Hours of Operation:

Ideally the program will be open from mid morning until evening hours during the week and will be open during the weekend and on holidays as well. Hours of operation will eventually be determined by the consumers and Board of Directors..

Intensity/Demand of Program:

Low demand. There is no required participation in programming. Supports, information and linkages are available as requested. Peer support groups, including DRA, are available if desired. Mostly, structured programming, when it does occur, results from the mutual planning of an activity or event that responds to the shared interests and needs of consumers at the time.

RECOMMENDATIONS

Phase 1

FY04 Budget – Pilot Project

- Use current resources and work with FMD to find existing unused lease space available within the county for a drop-in center.
- Use write up by work group as a guide to implement a one year pilot project to determine effectiveness of program
- Re-allocate internal resources to fund a pilot.
- Do a needs assessment to determine where drop-in services are most needed within the county.

Phase 2

FY05 Funding – Possible Second and Third Locations

- Prepare RFP and select vendor(s) to operate programs
- Examine all funding sources, including grant monies, block grant funds, CCFP funds, private fundraising, and internally reallocated resources.

Community Readiness and Support

Service Description

A day treatment program that consists of psycho-educational, prevocational and group treatment modalities designed for adults with serious mental illness and/or substance abuse disorders. There are two basic components. The first component focuses upon assisting the consumer to improve living skills needed for successful community living. The second component focuses upon drug and alcohol education, prevention, relapse prevention and recovery. The first component is offered in the a.m. and the second component is offered in the p.m.

Eligibility and Exclusion Criteria

Adults 18 years of age or older with a serious mental illness, who resides in Fairfax County, or the cities of Fairfax and Falls Church. Currently receiving mental health services through Fairfax-Fall Church Community Services Board Mental Health Disability Area, do not require skilled nursing care, are mobile and able to provide their own personal care, and are motivated to improve community living skills.

Consumer Profile

- Benefit from flexible individual attention
- May benefit from higher level of monitoring
- May be dual diagnosis – (SMI With Alcohol/Drug Issues)
- Can benefit from help with socialization skills
- Can benefit from work on establishing or maintaining interpersonal relationships
- Get over stimulated and/or overwhelmed in large group setting
- At risk for hospitalization
- Homeless or at risk for homeless
- Difficulty recognizing personal danger

Program Purpose

To provide a therapeutic environment which promotes restoration, recovery and success in targeted areas.

Services Provided

Activities in modules: Self-Management, Interaction and Communication, Home Management, Community Management, Budgeting, Psycho-education on Mental Illness, Susbstance Abuse Treatment and Relapse Prevention, Human and Civil Rights, Self Esteem, Wellness, Addictions, Cultural Diversity, Pre-vocational and Recreation/Relaxation.

Capacity

20 male and female adults with 10 to 12 in the morning group and 8 to 10 in the afternoon group.

Staff To Client Ratio

Two staff for a group of ten to twelve.

Length Of Stay

Average of twelve months and a maximum of eighteen months.

Level Of Supervision and Monitoring

Individual attention is given when necessary. Consumers are visually monitored through out the day. Staff are present and with consumers upon their arrival and until they return to their residence.

Location

Current program is located at our Springfield Mental Health Site. There is a need to have the same program located in the South part of the county and North part of the county.

Termination, Transition and Discharge Criteria

Termination occurs when the consumers accomplished their goals or when they are ready to transition to next level of care. Transition occurs when consumers are determined to need a different program or when they have accomplished their goals. Discharge occurs only when consumers continues to consistently fail to show up, refuse to participate and show aggression toward others after staff have made a concerted effort, using all of their professional skills and knowledge, to bring about a positive change.

Intensity/Demand Of Program

High expectation, high monitoring, low demand and flexible services tailored to individual needs.

How To Apply and Admission Procedures

Case Manager must completed a Recovery and Rehabilitation Support Services screening and ensure that a face to face diagnostic assessment is completed to determine consumer needs. Case manager will make a referral to the Coordination and Planning Team once the screening and diagnostic assessment are done. Case manager must ensure required authorization and re-authorizations are done for needed services.

Pychosocial Rehabilitation Services Description

Service Description:

Traditional PSR program. Activities include work units, psychoeducational groups, social activities and individual counseling. Program structure is flexible and can accommodate varying levels of participation. The focus of all program activities is to teach skills and provide supports for community integration, work readiness and independent living. Participants will be assessed and encouraged to develop readiness for change to promote recovery and wellness.

Program Purpose:

To provide a structured rehabilitation program in which consumers learn skills and utilize resources to further goals of employment, school, social interaction and independent living. Services are provided in a community-setting that promotes wellness and recovery. Goals include:

1) To provide a state-of-the-art psychiatric rehabilitation program, consistent with the current research findings in the field and the IAPSRS Practice Guidelines.
2) To provide the technology and resources for staff and consumers to access updated/current information relevant to psychiatric rehabilitation and ***the concept of recovery.***
3) To empower individuals to make informed decisions in goal-setting and take responsible action in attaining them.
4) To provide an array of services and supports within the program that is responsive to multicultural diversity.
5) To provide opportunities for consumers to develop and implement a Relapse Management Plan to ***promote recovery.***
6) To provide opportunities for consumers to develop and enhance independent living skills in order to reside in a ***least restrictive*** setting.
7) To assist consumers in acquiring interpersonal skills that will enable them to develop a community-based ***natural support*** *network.*
8) To provide technical assistance and support to consumers interested in developing leadership and advocacy skills.
9) To provide opportunities for individuals to develop a meaningful identity as a worker in order to enter or re-enter the workforce.
10) To assist individuals in fully understanding and assessing their present skills, strengths and needs as a worker.
11) To provide opportunities for individuals to develop a meaningful identity as a student in order to pursue goals of higher education.
12) To assist consumers who are dually diagnosed with a serious mental illness and substance abuse/dependence in fully understanding the

interplay between substance use and mental illness and the impact on role-functioning.

13) To promote and encourage individuals to explore opportunities to ***enhance a healthy lifestyle*** which will support recovery.

14) To collaborate and coordinate with other service providers, family and significant others to enhance a consumer's ability to ***achieve an overall rehabilitation goal.***

15) To monitor outcomes and level of satisfaction with services in order to improve the quality of services.

Eligibility and Exclusionary Criteria:

Any consumer with a mental illness and a moderate to serious impairment in role functioning. The consumer should desire to participate in the services and be able to be served in an environment that provides supervision with a staff to consumer ratio of 1:20. Individuals need to be willing and able to maintain personal safety. There is an expectation that consumers remain on the program site or notify program staff if they are leaving. Consumers must accept personal responsibility for their presence at the site. Individuals with unameliorated violence or predatory behaviors may be excluded. Individuals with substance abuse or mental retardation as primary diagnoses will be excluded.

Consumer Profile:

Adults with serious mental illness and a moderate to severe functional impairment. Consumers will most likely need long-term treatment and support (greater than six months.)

How to Apply:

Referrals come through the Referral and Placement Team.

Staff from the Community Services Board, discharge planners from the State Hospitals, consumers and/or family members may initiate referrals. A referral form is completed at this time, along with diagnostic information and prescribed medications, to be provided by the consumer's primary therapist/case manager and/or treating physician.

Admission Procedure:

Face to face intake assessment completed by a licensed mental health professional (Medicaid requirement to establish clinical necessity).

Acceptance into the program will be dependent on an opening and/or funding stream to cover the cost of the service. The Fairfax Falls Church CSB may pay for the service for residents of the County, a consumer may have third party insurance or the ability to pay privately. County funded residents are responsible for a sliding scale fee, the exception

are those residents who have Medicaid. Screenings provide an opportunity for consumers and family members, if appropriate, to visit the program, gather information and ask questions to make an informed decision regarding use of services. An intake is scheduled to gather information and complete an initial assessment to assist the consumer in beginning the process of establishing goals and objectives to engage in service(s).

Within the first 30 days of admission to the day program, a Needs Assessment is completed by the consumer and his/her PSR I case manager. Other care-providers, the referral source, family and/or significant others are invited to assist in the process of determining programmatic needs with the consent of the consumer served. An Initial Recovery Plan (up to 30 days) focuses on orientation activities and provides baseline data to evaluate a consumer's needs and abilities.

Staff and consumers establish an Overall Goal after completing a Need's Assessment which evaluates strengths and/or limitations experienced in a variety of life domains such as; housing, physical health, mental health, social, financial status, spirituality, substance abuse, education, employment, etc. After establishing the Overall Goal, identified skills and needed resources will be incorporated into an Individual Recovery Plan.

Assessments are completed with consumers. Input from the consumer, and with the consent of the consumer, family and other service providers work as a team or develop a partnership to provide integrated services. The assessments require that skills be defined in language comprehensible to the consumers. The consumer and staff establish both the present level of functioning and the needed level for each necessary skill. Assessments begin with the consumers' perception of skill strengths and deficits. In this way, trust is established and base line data is collected.

Support Network and Family Involvement:

Family involvement in the recovery process for individuals with psychiatric disabilities is a significant asset. Welcoming and strengthening this asset entails both providing direct education and support to families and incorporating them as fully as possible into the process of outreach, assessment and treatment of their loved ones.

Within PSR I, family involvement is explored with consumers at Intake and is ongoing, as appropriate. The multitude of ways families may involve themselves in services is articulated so that consumers are aware that this can involve anything from active participation in the treatment team to parents enrolling in a general mental health awareness class to a daughter receiving an agency newsletter. The level of family involvement is ultimately the consumer's choice and can be declined. However, as research clearly demonstrates the positive impact of family involvement in the recovery process, this issue is respectfully raised periodically over time to ascertain whether this involvement might be agreed upon at a later time. It is the goal of PSR I to have families involved as fully as possible.

When appropriate, and with relevant consumer consent, more structured services are provided to families. Based on consumer readiness and the needs of the family at the time, two services are available. The first is a Family Education Series that begins with a series of 6 weekly sessions that provides an overview of psychiatric disability, psychotropic medications, legal issues in Mental Health and available resources. An optional 4-week follow-up series, on specific skills building (effective communication, assertiveness, engaging community supports and preventing burnout), is then offered.

The second service is Family Consultation. This is focused, family-specific work that provides individualized, professional consultation to a given family with the goal of enhancing that family's ability to cope with the realities of psychiatric disability as it effects them. The approach is one of collaboration and openness and encompasses a "strengths" perspective. The family sets the agenda and decides when progress has been made. The use of Family Consultation is most appropriate when there is a significant commitment among family members and the consumer to address specific issues, which, once resolved, will allow for significant improvement in consumer functioning and overall family health.

Consumer Involvement:

In reviewing the array of services, note that interested consumers are involved in planning needed services within the program structure via planning meetings, house/community meetings, and/or focus groups. All consumers develop an Individual Recovery Plan to determine needed services and supports to reach identified goals/objectives. All consumers are invited to complete evaluation surveys to determine needed changes to enhance program services on an annual basis. Consumers serve on the board of the contract agency, in work-groups as appropriate, and receive mentoring and/or training on advocacy.

Crisis Intervention/Management:

Crisis intervention is defined as short-term counseling designed to prevent exacerbation of a condition, to prevent injury to the consumer or to others, and to provide treatment in the least restrictive setting. Crisis intervention will include a face-to-face assessment of the consumer to determine the nature of the crisis situation, short-term counseling of the consumer, either alone or with family members, access to Emergency Services at the CSB and linkage to long-term service to prevent future crises.

Array of Services Provided:

- Services include work units and activities that are essential for day to day operation of the program
- Dual diagnosis group and individual counseling
- Employment services including situational assessment, job development and employment support
- Psychoeducational groups

- Individual supportive counseling
- Crisis intervention
- Peer Support Groups

PSR I is designed to provide consumers with opportunities to minimize functional deficits. Unit work is the day-to-day work needed to keep the program up and running effectively. Consumers engage in the day-to-day running of the program and assume leadership roles when appropriate in working toward recovery.

Consumers engage in work units to improve concentration, build stamina, develop skills in a variety of domains, etc. Productive engagement in helping the program run efficiently builds self-esteem and demonstrates that consumers are wanted, needed, and valued for their contributions to the program. Skills can be enhanced and/or developed to increase independent living and movement toward recovery. Consumers are encouraged to develop advocacy and leadership skills and may take on supervisory roles in the units. Consumers and staff work side-by-side in the units. The type of work required for each program may vary. Therefore, units at each location may be defined based on staff and consumer input at that site. The unit work is scheduled through out the day.

Direct-skill teaching and support groups are offered. *Direct-skill teaching groups* cover topics, such as *Understanding Your Illness, Relapse Management, Healthy Living, Stress Management Techniques, Anger Management,* and the *Purpose and Side Effects of Medications, etc. Support groups* may be developed to meet the needs of persons served. Examples are *Dual Recovery Anonymous* and a *Diabetes Support Group.*

Consumers take an active role in providing leadership for both the educational and in-house support groups. Groups developed will reflect the diversity of consumers served and be responsive to ethnic, cultural, and spiritual traditions that consumers bring to the program

Consumers are encouraged to become involved in the Tri-Center Advocacy Group where advocacy skills are taught and role-modeled within this group. Consumers are encouraged to seek information regarding pending legislative and/or community issues that might be important to them as consumers. The Substance Abuse component of the program encourages consumers to link with a variety of self-help groups such as AA, DRA, etc.

Adult education classes provide consumers an opportunity to acquire a GED, improve basic math, reading, spelling skills, etc. Daily living skills like reading a grocery label and managing a checkbook are incorporated into the classes. English-speaking classes are included in the program to increase English-speaking skills for a number of consumers who have English as a second language. Consumers interested in higher education are given assistance in applying for college-based courses and/or technical programs. Services might include skill teaching to aid consumers in normalizing social/interpersonal experiences, scheduling classes, managing study time and accessing extracurricular activities.

Outreach is provided to consumers who may be unable to attend the day program for a variety of reasons; recuperating from surgery, hospitalization, increased social isolation, etc. Outreach may be a phone call or perhaps a visit to the home, hospital or local McDonald's. Other consumers frequently accompany staff to see a consumer who is ill and is in need of outreach.

Some consumers will require engagement, or skill teaching within the community to move to the point where they are ready for PSR I. For those consumers, Mental Health Support Services may be indicated.

A deployed CSB psychiatrist can provide medication reviews during the course of the day.

Upon intake all consumers complete a Substance Abuse Assessment. Consumers are encouraged to address managing symptoms of illness and substance abuse/dependence concurrently. This is essential for consumers to achieve overall goals established. Individual counseling and a variety of groups ranging from educational, support and self-help groups address concurrent disorders.

Each consumer served will have a designated case manager assigned to orient the consumer to the services and coordinate the provision of all services offered, including employment services. With consent linkages are established with other service providers and family members to coordinate the array of services and support needed to support recovery goals. Outreach is provided when a consumer demonstrates difficulty following through on the agreed-upon Individual Recovery Plan.

A treatment team, composed of service providers currently involved with the consumer, will serve each consumer; these providers may be both internal and external. The case manager coordinates service internally, as well as with those services offered by other organizations.

A management information system tracks consumer information, program services and outcomes. Consumers are asked to complete satisfaction surveys, participate in focus groups, if indicated, and provide feedback so that quality services are provided. Input is encouraged at community and/or planning meetings to change or update the PSR I program to meet consumer needs.

Capacity:

Three locations. Capacity to be determined by the number of staff available/funded and the size of the facility housing the specific program. Current resources allow for 383 consumers served per year annualized across all sites. Current average daily attendance at each site:

South County: 81
Central County: 55
North County: 31

Location:

Three centers spaced across Fairfax County-Falls Church (South County, Central County and North County).

Length of Stay:

Range six months to 10 years (average 18 months to two years). Outliers have needed the service ten plus years.

Termination, Transition and Discharge Criteria:
Consumer choice.When a consumer is no longer in need of the services and supports as demonstrated by an independent level of community functioning. This would include, at a minimum, the ability to structure time, follow a daily regimen, have productive activities and keep appointments. As readiness to change becomes clearly defined, the consumer may transition to more intensive services such as Employment Services or PSR II.

A Membership Agreement is signed upon admission to PSR I. This outlines expectations of behavior in the program and identifies threatening behaviors, both verbal and physical, as well as active substance abuse in the program, as criteria for time-limited suspension or possible termination. Prior to termination, however, a number of steps are taken to assess reasons for inappropriate or threatening behavior and efforts are made in conjunction with other care-providers/families to address the barriers encountered. Staff ultimately need to review and decide whether the program can continue to serve an individual if that consumer violates the Membership Agreement and disrupts services provided to other consumers to ensure an environment that is both safe and conducive to recovery or personal growth opportunities.

Consumers are encouraged to identify an Overall Goal to achieve in the Individual Recovery Plan. Discharge criteria are identified, as the plan is developed, to indicate when the consumer may no longer need or require the current level of intensity of service provided by PSR I. Criteria are reviewed and redefined based on the Individual Recovery Plan. The discharge criteria reflect the ability to sustain performance of role-changes (identified goals and objectives) for a period of time that will support a consumer in movement toward recovery. This is individualized for each consumer served.

Level of Supervision and Monitoring:

A staff/consumer ration of 1/20 precludes intensive monitoring. Consumers may come and go as they wish. It is possible to provide intensive supervision only during acute crisis situations.

Intensity/Demand of Program:

Low intensity. The program is designed to encourage each participant to have responsibilities within the program. Willingness and ability to engage and participate will impact other consumers served within the program, as there is mutual reliance for lunch being prepared and served, etc. Consumers are always encouraged and challenged to actively participate in a variety of services offered within the site. Peer support is an essential ingredient to role model success and movement toward recovery. Some persons served may be able to contribute at a minimal level while others demonstrating readiness to change and movement towards recovery will take on leadership roles. As long as there is a balance within the environment, the setting can facilitate investment in recovery.

Staff/consumer ratio:

One staff per 20 consumers.

Revenue Maximization possibilities:

For consumers with Medicaid, SPO billing covers partial costs of psychosocial rehabilitation. If Mental Health Support Services being provided, and consumer has Medicaid, SPO billing. For consumers without Medicaid, supplemental grant funding such as CCFP, United Way or HUD. (in addition to CSB funding). Bill Medicaid for Crisis Intervention Services.

Employment Services

Description

Employment Services run the gamut from teaching skills needed to return to work to supporting consumers already in competitive careers during episodic symptoms. It is the major emphasis for some consumers. It focus on employers expectations, how a return to work impacts government benefits, skills required in work setting, job search, job choosing, employment skills maintenance, job retention and career. Employment may be competitive employment or supported employment, but competitive employment is always the goal whenever possible.

Purpose:

The focus is to capitalize on the motivation and readiness of a consumer to move forward in the recovery process. The program is designed to maximize financial empowerment through the provision of wages and benefits, promote work, and provide training in work related skills necessary to obtain and maintain employment.

Eligibility and Exclusion Criteria:

The Employment Services Program will serve individuals 18 years of age and older who have a psychiatric disorder on Axis I and/or a personality disorder on Axis II according to DSM IV. Co-occurring disorder of mental illness and substance abuse is included. These individuals will demonstrate a mild to severe impairment in role functioning secondary to psychiatric symptoms and/or behavior in at least one of the following spheres of functioning:

- Employment
- Educational
- Social
- Housing

Consumers need to demonstrate willingness and readiness to pursue individualized goals and objectives with a focus on recovery, increasing self-sufficiency and community integration. The consumer must be able to engage in services and able to participate in an intensively structured program three-four times per week at a staff to consumer ratio of 1:15.

Individuals with un-ameliorated violence or predatory behaviors may be excluded. Individuals with substance abuse or mental retardation as primary diagnoses will be excluded.

Consumer Profile:

Consumers with serious mental illness; who demonstrate cognitive abilities, stamina to develop and/or strengthen skills and a capacity to utilize resources to focus on an identified rehabilitation goal. Participants are able to formulate realistic goals and objectives that can be achieved within six to nine months. Consumers have developed readiness to make behavioral changes to promote wellness and community integration.

Readiness describes willingness and commitment to change, not necessarily capacity for change. A consumer's readiness changes over time and may be environmentally specific.

This program should be the *program of choice* for individuals who are:

- experiencing the first or second episode of mental illness
- transition students
- willing to learn new techniques and strategies to cope effectively with a mental illness
- ready to make changes in lifestyle to move into recovery
- in need of a *rapid return to work* focus
- in need of work adjustment training to return-to-work
- employed in professional or technically skilled areas when mental illness impacts on ability to maintain competitive employment

Services Provided:

80% of the Employment Program must focus on job choosing, job getting, job keeping, job coaching, and long term wage employment. However, since the program is designed for consumers with a mental disability, the provider must also focus on activities that maintain and sustain psychiatric stability and maintenance. Therefore, 20% of the Employment Program may be use for activities such as; medication management, relapse management, health care issues, substance abuse and co-occurring disorders, world of work and environmental stressors.

We expect 35% of the consumers attending each of the Recovery, Employment and Rehabilitation program will be referred to an Employment Specialist working in this program. Some consumers will be referred directly to the Employment Program and others will be referred after attending other programs.

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How to Apply:

Referrals come through the Referral and Placement Team and/or the Department of Rehabilitative Services.

Staff from the Community Services Board, discharge planners from the State/Private Hospitals, consumers, and/or family members may initiate referrals. A referral form is completed at this time, along with diagnostic information and prescribed medications, to be provided by the consumer's primary therapist/case manager and/or treating physician.

Admission Procedure:

Referral screened for readiness to focus on an identified recovery goal and/or return to work. Face-to-face intake assessment completed by a licensed mental health professional to establish clinical necessity for Medicaid/Non-Medicaid funded consumers. DRS referred consumers will be exempt from a LMHP assessment. An assessment will address measurable goals/objectives, the level of readiness and commitment to make changes to enhance recovery within a six to nine month time-frame.

Acceptance into the program will be dependent on an opening and/or funding stream to cover cost of the service. The Fairfax Falls Church CSB may pay for the services for residents of the county through a contract provider; a consumer may have third party insurance or the ability to pay privately. The Department of Rehabilitative Services may fund an array of employment services through a vendor agreement.

Needs Assessment and Planning for Recovery

All consumers will establish an *overall rehabilitation goal* that will drive the skills and objectives outlined in an Individual Recovery Plan. With consent of the person served, families and/or significant others will be involved in the assessment of needs and service planning as indicated. Goals and objectives will be measurable, written in behavioral terms, and consistent with language that is meaningful to the consumer. The expectation is that individuals will be able to access a variety of services and supports depending on the level/intensity required secondary to symptoms/dysfunction experienced. The consumer will be an active participant in this process.

A Needs Assessment will evaluate strengths, limitations and personal preferences in a variety of life domains such as; housing, physical health, mental health, social, financial status, spirituality, substance use/abuse, education, employment, etc. Skills and resource objectives will be identified to enhance role-functioning in the area in which the consumer chooses. Risk and readiness factors will be monitored and addressed regularly.

Support Network and Family Involvement:

Family involvement in the recovery process for individuals with psychiatric disabilities is a significant asset. Welcoming and strengthening this asset entails both providing direct education and support to families and incorporating them as fully as possible into the process of outreach, assessment and treatment of their loved ones.

Within Employment Services, family involvement is explored with consumers at intake and is ongoing, as appropriate. The multitude of ways families may involve themselves in services is articulated so that consumers are aware that this can involve anything from active participation in the treatment team to parents enrolling in a general mental health awareness class to a daughter receiving an agency newsletter. The level of family involvement is ultimately the consumer's choice and can be declined. However, as research clearly demonstrates the positive impact of family involvement in the recovery process, this issue is respectfully raised periodically over time to ascertain whether this involvement might be agreed upon at a later time. It is the goal of Employment Services to have families involved as fully as possible.

When appropriate, and with relevant consumer consent, more structured services may be provided to families. Based on consumer readiness and the needs of the family at the time, two services are available. The first is a Family Education Series that begins with a series of 6 weekly sessions that provides an overview of psychiatric disability, psychotropic medications, legal issues in Mental Health and available resources. An optional 4-week follow-up series, on

specific skills building (effective communication, assertiveness, engaging community supports and preventing burnout), is then offered.

The second service is Family Consultation. This is focused, family-specific work that provides individualized, professional consultation to a given family with the goal of enhancing that family's ability to cope with the realities of psychiatric disability as it effects them. The approach is one of collaboration and openness and encompasses a "strengths" perspective. The family sets the agenda and decides when progress has been made. The use of Family Consultation is most appropriate when there is a significant commitment among family members and the consumer to address specific issues, which, once resolved, will allow for significant improvement in consumer functioning and overall family health.

Consumer Involvement:

Interested consumers are involved in planning needed services within the program structure via planning meetings, house/community meetings, and/or focus groups. All consumers develop an Individual Recovery Plan to determine needed services and supports to reach identified goals/objectives. All consumers are invited to complete evaluation surveys to determine needed changes to enhance program services on an annual basis. Consumers serve on the board of the contract agency, in work-groups as appropriate, and receive mentoring and/or training on advocacy.

Crisis Intervention/Management:

Crisis intervention is defined as short-term counseling designed to prevent exacerbation of a condition, to prevent injury to the consumer or to others, and to provide treatment in the least restrictive setting. Crisis intervention will include a face-to-face assessment of the consumer to determine the nature of the crisis situation, short-term counseling of the consumer, either alone or with family members, access to Emergency Services at the CSB and linkage to long-term service to prevent future crises.

Capacity:

Caseload capacity for staff 1:15. The program will have the ability to serve 132 consumers per year if demand for services is warranted.

Location:

May be Co-located with other Recovery, Employment and Rehabilitation programs but have distinct groups/section of building at each site. There will be three locations across Fairfax County.

South County
Central County
North County

Length of Stay:

Six months for on-site facility-based services. A reassessment may provide an additional 3 to 6 months. Long term supports may be off-site in the community and can last indefinitely. The supports may be routine or episodic based upon need.

Termination, Transition and Discharge Criteria:

Consumer will have the choice to terminate at anytime they wish. If a consumer is unable to complete the intensive program or sets a goal that requires long-term rehabilitation, he/she may transfer to alternative services. Discharge criteria is identified by the consumer and staff as the Recovery Plan is developed and implemented.

Level of Supervision and Monitoring:

The staff to consumer ratio is 1:15. Consumers may come and go as they wish. It is possible to provide intensive supervision only during an acute crisis.

Intensity/Demand of Program:

High expectation and high goals are set. Numerous job assignments will be given and consumers must have a desire to be completed and perform task as directed. The program will focus on work skill and wage earning while effectively managing symptoms of illness (es) and activities to enhance recovery. It is expected that participants in this program will be committed to make lifestyle changes, recognize problem-areas and "want to" regain role-functioning in the community.

Staff/Consumer Ratio:

1:15

Revenue Maximization Possibilities:

Medicaid Psychosocial Rehabilitation provides partial reimbursement.
Mental Health Support Services
DRS will purchase specific employment services.
Bill Medicaid for Crisis Intervention Services.

Intensive Recovery Services (IRS)

Service Descriptions:

Intensive Recovery Services represent the boundary between consumers that can be safely treated in an outpatient, community based setting and those who require 24-hour care. It provides four hours per day of structured treatment for mental illness with or without a co-occurring substance abuse diagnosis. It involves a variety of therapeutic approaches including: Dialectical Behavior Therapy (DBT) Groups, Addiction Groups, Psychoeducational Groups, and Therapeutic Process Groups. Because it is a therapeutic milieu program, individual consumers function as part of a larger therapeutic community that provides collective feedback to each other about their shared recovery goals. Each treatment day is set up as an independent treatment module so that consumers can be scheduled for the level of service intensity they require. Conceivably, a consumer could start with one day, build up to four days, and then taper back off to one day. A person in more immediate need could start with all four days. Also, if needed, someone could attend Monday thru Thursday and then switch to Tuesday thru Friday if there was an extenuating scheduling circumstance.

There are additional early morning and evening components to this program. Consumers of Intensive Recovery Services are encouraged to participate in both Alcoholics Anonymous and Narcotics Anonymous as appropriate; the Intensive Recovery Services site at the NW Center has early morning AA meetings (7:30 am) that have been incorporated into the program and the Mt. Vernon Center has evening Narcotic Anonymous meetings. In addition there will be a weekly evening multi-family group that will serve as a resource for any family that has a member in treatment. There will also be a weekly evening transition group for clients who have completed Intensive Recovery but could benefit from some ongoing support. A regional pilot vocational component jointly operated by ACS, IRS, ARS, ES, PSR and the Department of Rehabilitative Services-DRS is a potential resource that would be available to all consumers in the area.

Eligibility and Exclusionary Criteria:

Eligible persons are adults 18 years or older with a serious mental illness (DSM-Axis 1) diagnosis with or without a co-occurring substance abuse diagnosis who reside in Fairfax County or the cities of Fairfax and Falls Church. Persons from other jurisdictions will be considered if there is no waiting list and they or their insurers are able to pay full fee for their service. Consumers are typically referred for psychiatric stabilization in a crisis or acute condition that requires this level of intensive service. To be eligible the consumer must meet the eligibility requirements for partial hospitalization services based on the criteria established by licensing regulations and DMAS regulations. Consumers are required to have some residential placement (shelters and temporary arrangements are acceptable) and be able to provide for their personal care. They must not represent a direct threat to other consumers. They must be able to tolerate the overt symptomotology some other consumers present and evidence the ability to respond to the challenge of

being part of an active therapeutic program that anticipates treatment change. The consumer must be willing to accept active substance abuse testing (urine and breathalyzer) and commit to the conditions of the individual therapeutic contracts they collaboratively participate in establishing.

Consumer Profile

- Major mental illness diagnosis with or without co-occurring substance abuse condition.
- In need of intensive treatment for psychiatric stabilization.
- Sufficient verbal/cognitive skills to participate in an active psychotherapy program.
- Ability to tolerate overt symptomatology in others.
- Able to accept active substance abuse testing including urine and Breathalyzer screens.
- Able to commit to and sustain the energy to participate for up to three to six months in an active, group therapeutic program.

Medicaid has four eligibility criteria for this level of service, of which each consumer will have to demonstrate at least two on a continuing or intermittent basis: 1) Have difficulty in establishing or maintaining interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community; 2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized; 3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; 4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Program Purpose

The purpose of Intensive Recovery Services is to provide:

- Intensive focused treatment of various psychiatric difficulties such as psychotic episodes, affective and anxiety disorders, personality disorders, mixed diagnosis disorders, and personal crises resulting in disruption of functioning.
- An alternative treatment to inpatient hospitalization that is community based and will serve as a diversion strategy for avoiding unnecessary hospitalization.
- Specialized intensive recovery services for those with co-occurring drug/alcohol and mental illness conditions.
- An intensive treatment setting that will assist in transition (step-down) from the structure of an inpatient facility to the community
- Services for those who have not responded to or been able to be stabilized using traditional outpatient services
- A community-based setting for diagnostic evaluation that includes psychiatric and functional assessment as well as medication and medical services.

Services Provided

Individual Sessions: Consumers will meet with their Intensive Recovery Services therapist on a PRN basis to clarify any individual concerns and deal with personal crises, but the program's philosophy is to focus treatment in the group modality rather than individual therapy. Group interaction fosters development of a support system that can be replicated outside of the therapeutic milieu.

Milieu: The IRS milieu provides a social setting during which consumers are encouraged to interact with others in order to improve appropriate social and interactive skills. During program hours consumers remain in the designated program area to foster the development of socialization skills as well as to prevent disruption in the service site.

Groups: The program consists of a variety of groups, which provide consumers with psychotherapy, Dialectical Behavior Therapy, psychoeducational opportunities, support and a means to discuss issues that foster personal growth and development. Upon entry into IRS, consumers are assigned to a group of eight to ten consumers, which is co-led by their therapist four times each week and offers consumers the opportunity to make changes in their lives by understanding more about how their feelings and behavior affect their lives, how to develop relationships, how to deal with conflict and anxiety, and how to solve problems. Each consumer is expected to share issues and to participate in the discussion of others' issues.

Chemical Dependency Group: This group meets two times a week and explores the physiological, psychological, and social aspects of drug and alcohol use and abuse. The group is designed to help consumers identify the areas of difficulty in their substance use, make changes in their lives, and seek appropriate additional treatment when indicated. It is the belief of the IRS program that individuals with psychiatric difficulties, which are further complicated by alcohol and drug problems, recover best in group settings.

Life Skills Group: This group is designed to help consumers learn about and practice a variety of personal growth skills. Topics include: personality style, constructive criticism, self-care, stress management, time management, leisure and recreation skills, communication skills, anger management, personal and home safety, and cognitive restructuring.

Wellness Group: This group focuses on attainment and maintenance of general health. It includes nutrition, exercise, review of common health related concerns and major illnesses as well as periodic review of current psychopharmacology.

Goals Review: This group reviews the consumer's daily progress, including whether or not they were successful in addressing their individual focus for the

day. As well, it provides the consumers the opportunity to address any concerns that remain. The group serves as appropriate closure to the treatment day and reinforces the structure of the program.

Multi-Family Group: This is an evening group that serves as a resource and opportunity for family members and significant others to have their questions answered and to discuss issues they are dealing with in the "home environment."

Other Services:

Medication: The staff psychiatrist and nurse see consumers for medication evaluations and monitoring. Consumers are sometimes joined by their therapist. Consumers may have significant others attend their medication appointment to address questions, concerns or observations of medication response. Any medication issues can be brought to the attention of the program nurse during program hours or after hours to emergency services.

Lab Work: Consumers will be referred for lab work as needed. Labs are drawn as needed.

Referrals for Other Services: A consumer's therapist can assist the consumer by making referrals to various agencies such as the Department of Social Services, the Virginia Department of Rehabilitative Services, and the Virginia Employment Commission. The therapist will also help a consumer to obtain follow-up medical treatment, therapy, or medication after leaving the program

Capacity:

20 coed adults at the Northwest Community Mental Health Center (Reston) and 24 at the Mt. Vernon Community Mental Health Center.

Location

Programs are currently located in the North and South parts of the county. Both programs are located within CSB Community Mental Health Centers (Mt. Vernon and Northwest) in layouts that were specifically designed for day treatment programming. Both programs have their own dedicated vans and drivers which allows them to help with the transportation of consumers who are "landlocked" in the suburbs or are too symptomatic to use public transportation.

Length of Stay

The program is designed for up to three months of treatment, but consumers who stabilize more rapidly and do not need additional treatment often leave more quickly. Discharge and length of stay are often determined by the availability of appropriate

resources to support a realistic transitional plan that will not be a completely inappropriate step-down from the Intensive Recovery Services treatment experience. The average length of stay for the program in FY' 2002 was 54 treatment days. Consumers who have completed treatment but are waiting for acceptance into other programs will often maintain a follow-along relationship with their therapist in the program. The time frame of the program is designed to accommodate the types of consumers referred to IRS and the treatment objectives. The largest combined referral source for both programs is currently direct psychiatric hospital discharges. Many of these consumers have had acute psychiatric breaks or are newly diagnosed with serious mental illness. They often come out of the hospital over medicated on complex regimes of psychotropic and physical medications that must be carefully titrated back to a functional community level. These consumers often need intensive services such as residential and these scarce resources require much of the treatment period for the application process. The CSB's outpatient programs also refer a large number of consumers who cannot be stabilized on an outpatient basis and require significant treatment to determine what psychiatric issues must be resolved in order to restabilize them in the community. Another major referral source is the CSB's Alcohol and Drug Services who refer many of their most difficult dually-diagnosed consumers who are often battling a number of co-occurring conditions and have had little or no treatment for their mental health condition. Consumers with substance abuse conditions often require additional time to allow for the physiological changes that take place in the recovery process.

Termination, Transition and Discharge Criteria

Discharge occurs when consumers have reached their treatment goals or the program's time constraints. Many consumers transition before this point because they have improved or stabilized to the point that they can be maintained with less intensive services while continuing to work on the treatment issues identified in IRS. This often occurs in the case of consumers who have a vocational or residential opportunity that presents itself and the consumer/program feel they must take advantage of it. There is a weekly transition group that is open to all clients who need to continue to use the program as a support resource.

Consumers who came into IRS having an existing treatment relationship with the CSB have their therapists or case managers retain case management oversight. They are also involved with IRS in transitional planning and transition/discharge is a coordinated plan involving IRS staff, the parent program's staff and the client plus his family &/or significant others.

Termination from the program is considered:

- when the consumer is not capable of effectively participating in the interactive or cognitive aspects of the therapeutic program and this inability is causing undue stress on the other consumers as well as the individual.
- is not able to tolerate the symptomatology or illness related communication of other consumers.

- poses a threat to the physical and psychological safety of other group members.
- does not reliably attend
- does not live up to the conditions of his treatment contract.
- does not accept substance abuse testing (urine and breathalyzer)

Level of Supervision and Monitoring

All Intensive Recovery Services consumers have an individual therapist who they meet with on an as needed basis, but the IRS program philosophy is to focus treatment in the group rather than individual modality. This emphasis means that consumers are with staff throughout the program day. Consumers' attendance in the program is monitored by staff using a log that checks them in and out of every major activity during the day. This level of specificity was initially designed for billing purposes, but it also allows for precise documentation and monitoring of a consumer's participation in the program.

Consumers are required to reliably attend the program as a condition of treatment and may be terminated for non-attendance. Consumers who are a no show for a scheduled treatment day are followed up by phone or other appropriate means. Consumers are typically with at least one staff member at all times and eat lunch with the staff.

Staff to Client Ratio

Staff typically carry an internal case load of five individual consumers plus several consumers who are transitioning out of treatment but require follow-along services. Each staff member also has responsibility for conducting intake evaluations and supporting all of the casework involved in this process.

Since the IRS group milieu is so labor intensive, the average line therapist spends 65% or more of his/her time in direct contact with the consumers. This typically includes preparing and eating lunch with the consumers as part of the treatment day.

Intensity/Demand of Program

IRS is the most intensive level of community-based service available in an outpatient, community based format. Treatment plans are typically based on an active psychotherapy agenda with specific out-comes and goals. The variety of tasks/expectations during the program day requires both physical and psychic energy. The verbal and reasoning skills necessary to participate in the psychotherapeutic portion of the program are demanding. The therapeutic milieu model also means that participants are rarely alone and are required to adapt to the peer environment.

- High Intensity
- High Demand

- Close Monitoring

How to Apply and Admission Procedures:

Case manager or referring agent must complete a Consolidated Day Continuum Application that includes a screening and diagnostic assessment to assure appropriateness of referral. In routine cases, this application will be evaluated by the Integrated Referral and Transition Team, which will involve the referring source as appropriate.

In emergency situations such as direct hospital discharges or hospital diversions that can not follow the routine protocol, the admission protocol will still utilize the Consolidated Day Support Application, but it will be evaluated by the IRS program which will coordinate closely with the leadership of the IRTT about the appropriateness of the referral relative to the existing prioritized needs for these services.

Revenue Maximization

Due to its group milieu model, IRS is one of the most economical and cost-effective MH services available. Relative to the high intensity of service it provides, it is a relative bargain when compared to other com-parable levels of service. This consideration is an important revenue maximization strategy since it prevents the CSB from over-expending on other more expensive services.

IRS is currently on target to exceed its FY03 revenue goal of $112.000. This amount is largely made up of Medicaid dollars, but private insurance is becoming an increasing portion. Direct client fees are bolstered by an increasing number of cases set at full fee.

IRS will be billable through Medicaid and will deliver eight billable Partial Hospitalization units per week for someone in the full program.

Current cost to the CSB for each delivered IRS day of treatment per client is $136.75. Costs for the proposed IRS model discussed here are not yet determined, but this model also holds out the possibility of billing for the Focused Treatment (FT) track, in addition to the IRS track, utilizing the same basic resources.

Family Involvement / Support

The proposed multi-family group supported by IRS staff would be open to any family of a consumer engaged in client services. Although the proposed IRS model does not allow for ongoing individual family sessions there will be opportunities for family to meet with staff, with the consumers consent, to discuss their observations and concerns.

Crisis Intervention/Crisis Stabilization

There may be times when a consumer is in a situational crisis and needs urgent assistance. The IRS expectation is that consumers will utilize the program to

communicate concerns prior to the end of the day. The IRS therapists will assist in addressing concerns and in identifying a plan for management. If a crisis occurs outside of program hours, the consumer may request assistance through emergency services. Emergency Services at Woodburn are available when Intensive Recovery Services staff or Emergency Services at the Mount Vernon or Northwest Centers cannot be accessed.

Focused Treatment (FT)

Service Descriptions:

The FT Program is a two-hour group program that operates 3 days a week (M, W, F). It has two hour long groups at each session with a fifteen-minute break between them.

This program is designed to deliver focused treatment to consumers who cannot be successfully treated with traditional mental health outpatient service or therapeutic milieu models. It directly addresses symptomatic behavioral issues and includes medication and medical services. It provides diversion from impending hospitalization and "step down" from hospitalization if psychiatric hospitalization has occurred, but its primary function is to provide an early intervention/prevention strategy against unnecessary hospitalization by anticipating and defusing the acute situational crises that often lead to hospitalization in this target population. It focuses treatment on consumers with DSM mixed Axis diagnoses or primary Axis II diagnoses which require intensive treatment, but who may not be able to tolerate the more immersive Intensive Recovery Services (IRS) program.

There are potential, additional early morning and evening components to this program. Consumers involved in FT are encouraged to participate in both Alcoholics Anonymous and Narcotics Anonymous as appropriate; the FT site at the CSB's NW Center has early morning AA meetings (7:30 am) that have been incorporated into the program and the Mt. Vernon Center has evening Narcotic Anonymous meetings. In addition there will be a weekly evening multi-family group that will serve as a resource for any family that has a member in treatment. There will also be a weekly evening transition group for consumers that have completed FT but could benefit from some ongoing support. A proposed, regional pilot, vocational component jointly operated by the CSB (ACS, IRS, ARS, ES), PSR and the Department of Rehabilitative Services-DRS would be available to all consumers in the South County area.

Eligibility and Exclusionary Criteria:

Eligible persons are adults 18 years or older with a mental illness diagnosis who reside in Fairfax County or the cities of Fairfax and Falls Church. Persons from other jurisdictions will be considered if there is no waiting list and they are able to pay full fee for their service. Consumers will typically be referred for psychiatric stabilization in an acute condition that requires this level of service. Most referred consumers will have a poor history of treatment success in less focused and structured programs. Consumers are required to have some residential placement (shelters and temporary arrangements are acceptable) and be able to provide for their personal care. They must not represent a direct threat to other consumers. They must be able to tolerate the overt symptomatology some other consumers present and evidence the ability to respond to the challenge of being part of an active therapeutic program that anticipates treatment change. The client must be willing to accept active substance abuse testing (urine and breathalyzer) and

commit to the conditions of the individual therapeutic contracts they participate in establishing.

Consumer Profile

- Mental illness diagnosis
- In need of focused treatment for psychiatric stabilization.
- Diagnostically complex, high risk for impulsive behavior, low stability, mixed Axis or Axis II diagnoses including BPD, possible neurological/ organic involvement, substance abuse, forensic involvement, difficulty with interpersonal relationships and poor socialization skills
- Ability to tolerate overt symptomatology in others.
- Able to accept active substance abuse testing including urine and Breathalyzer screens.

Medicaid has four criteria, of which each consumer will have to demonstrate at least two on a continuing or intermittent basis: 1) Have difficulty in establishing or maintaining interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community; 2) Require help in basic living skills such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized; 3) Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary; 4) Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Program Purpose

The purpose of Focused Treatment is to provide:

- Focused treatment and community stabilization of various psychiatric difficulties such as psychotic episodes, affective and anxiety disorders, personality disorders, mixed diagnosis disorders, and personal crises resulting in disruption of functioning. Focus of treatment will include early intervention to prevent unnecessary psychiatric hospitalization by anticipating and "defusing" the situational crises in which this consumer group often becomes involved.
- An alternative treatment to inpatient hospitalization that is community based.
- A treatment setting that will assist in transition (step-down) from the structure of an inpatient facility to the community
- Services for those who have not responded to or been able to be stabilized using traditional outpatient services
- A community-based setting for extended diagnostic evaluation that includes psychiatric and functional assessment as wall as medication and medical services.

Services Provided

Individual Sessions: Consumers will individually see their FT therapist on an as needed basis to clarify any individual concerns and deal with personal crises, but the program's philosophy is to focus treatment in the group modality rather than individual therapy. Group interaction fosters development of a support system that can be replicated outside of the program.

Program Context: FT provides a group treatment setting with breaks during which clients are encouraged to interact with others in order to improve appropriate social and interactive skills. During program hours, clients remain in the designated program area to foster the development of socialization skills as well as to prevent disruption in the larger community mental health center sites.

Groups: The program provides the client with six major groups during the program week:

Dialetical Behavior Therapy Groups: These group sessions are designed to afford these clients a new, non-traditional form of therapy that allows them to discover new behavioral approaches to solve complex problems in a more concrete, understandable way

Psycho-Educational and Experiential Groups: These groups use a wide variety of formats to challenge consumers to see their problems through new perspectives. Some utilize traditional educational approaches to promote better understanding of mental illness, substance abuse, interpersonal dynamics, etc. The experiential approaches may also use focused strategies to help more non-verbal clients act out or otherwise express their problems.

Life Skills Group: This group is designed to help consumers learn about and practice a variety of personal growth skills. Topics include: personality style, constructive criticism, self-care, stress management, time management, leisure and recreation skills, communication skills, anger management, personal and home safety, and cognitive restructuring.

Wellness Group: This group focuses on attainment and maintenance of general health. It includes nutrition, exercise, review of common health related concerns and major illnesses as well as periodic review of current pharmacology.

Stability Group: This group ends the treatment week and allows consumers to discuss and plan for their safety and stability over the weekend and to discuss their progress and goals for the next week.

Multi-Family Group: This is an evening group that serves as a resource and opportunity for family members and significant others to have their questions answered and to discuss issues they are dealing with in the "home environment."

Other Services:

Medication: The staff psychiatrist and nurse see clients for medication evaluations and monitoring. Consumers may be joined by their therapists. Consumers may have significant others attend their medication appointment to address questions, concerns or observations of medication response. Any medication issues can be brought to the attention of the program nurse during program hours or after hours to emergency services.

Lab Work: Clients will be referred for lab work as needed: labs are drawn as needed.

Referrals for Other Services: A consumer's therapist can assist the consumer by making referrals to various agencies such as the Department of Social Services, the Virginia Department of Rehabilitative Services, and the Virginia Employment Commission. The therapist will also help a consumer to obtain follow-up medical treatment, therapy, or medication after leaving the program.

Capacity:

8 coed adults at the Northwest Community Mental Health Center (Reston) and 12 at the Mt. Vernon Community Mental Health Center.

Location

Programs are currently located in the North and South parts of the County. Both programs are located within CSB Community Mental Health Centers (Mt. Vernon and Northwest) in layouts that were specifically designed for group treatment programming. Both programs have their own dedicated vans and drivers which may allow them to help with the transportation of consumers who are "landlocked" in the suburbs or are too symptomatic to use public transportation.

Current van driver resources will not allow the vans to fully operate for both the IRS and FT programs. Additional resources will be needed to make that happen.

Length of Stay

The program does not have a specific time limit or length of stay.

Termination, Transition and Discharge Criteria

Discharge occurs when clients have reached their treatment goals. Some consumers may transition to other services because they have improved or stabilized to the point that they can be maintained with less intensive services while continuing to work on the treatment issues identified in FT. This often occurs in the case of consumers who have a vocational or residential opportunity that presents itself and the consumer/program feels they must

take advantage of it. There is a weekly transition group that is open to all consumers who need to continue to use the program as a support resource.

Consumers who come into FT having an existing treatment relationship with the CSB will have their therapists or case managers retain case management oversight. Parent unit staff will also be involved with FT staff in transitional planning; transition/discharge is a coordinated plan involving IRSstaff, the parent program's staff and the consumer.

Termination from the program is considered when the consumer:

- is not able to tolerate the symptomatology or illness related communication of other consumers.
- poses a threat to the physical and psychological safety of other group members.
- does not reliably attend
- does not live up to the conditions of his treatment contract.
- does not accept substance abuse testing (urine and breathalyzer)

Level of Supervision and Monitoring

All FT consumers will have an individual therapist who meets individually with them on an as needed basis, but the FT program philosophy is to focus treatment in the group rather than individual modality. This emphasis means that consumers are with staff throughout the program. A consumer's attendance in the program is monitored by staff using a log sheet that checks each consumer in and out of every major activity. This level of specificity was initially designed for billing purposes, but it also allows for precise documentation and monitoring of a consumer's participation in the program.

Consumers are required to reliably attend the program as a condition of treatment and may be terminated for non-attendance. Consumers who are a no show for a scheduled treatment session are followed up by phone or other appropriate means. Consumers are typically with at least one staff member at all times.

Staff to Client Ratio

Staff typically carry an internal case load of six individual consumers plus several consumers who are transitioning out of treatment but require follow-along services. Each staff member also has responsibility for conducting intake evaluations and supporting all of the casework involved in this process.

Since the FT group format is so labor intensive, the average line therapist spends the majority of his/her time in direct contact with the clients.

Intensity/Demand of Program

Treatment plans are typically based on specific outcomes and goals. The variety of tasks/expectations during the program week requires both physical and psychic energy. The FT group therapy model also means that participants are rarely alone during the program time and are required to adapt to the peer environment. This required participation is often a challenge to individual consumers who may typically practice isolative behavior or do not have appropriate interpersonal skills

- Moderate Intensity
- Moderate Demand
- Close Monitoring

How to Apply and Admission Procedures:

Case manager or referring agent must complete a Consolidated Day Continuum Application that includes a screening and diagnostic assessment to assure appropriateness of referral. In routine cases, this application will be evaluated by the Integrated Referral and Transition Team (IRTT) which will involve the referring source as appropriate.

In emergency situations such as direct hospital discharges, the admission protocol will still utilize the Consolidated Day Continuum Application, but it will be evaluated by the FT Program which will coordinate closely with the leadership of the IRTT if the appropriateness of the referral is in question.

Revenue Maximization

Due to its group milieu model, FT is one of the most economical and cost-effective MH services available. Relative to the high intensity of service it provides, it is a relative bargain when compared to other comparable levels of service. This consideration is an important revenue maximization strategy since it prevents the CSB from over-expending on other more expensive services.

Earned revenue is projected to be largely made up of Medicaid dollars, but private insurance will also represent a portion. Direct client fees will also contribute to overall revenue.
Current cost to the CSB for each delivered Partial Hospitalization day of treatment per client is $136.75. Costs for the FT model are not yet determined, but this model utilizes the same cost effective format of group therapy so its cost will be very competitive.

Family Involvement / Support

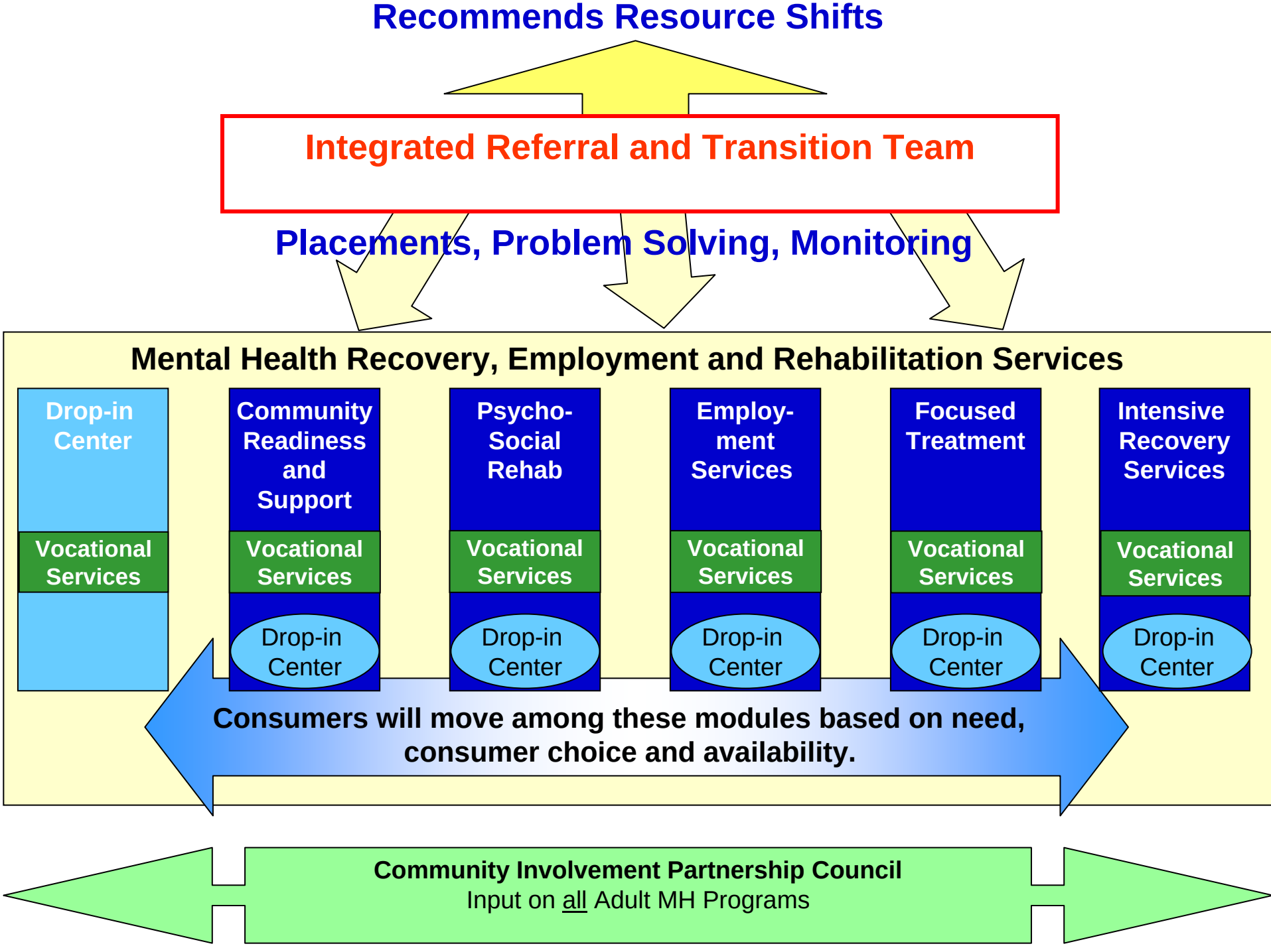
The proposed multi-family group would be open to any family of a consumer engaged in FT services. Although the FT model does not allow for ongoing family sessions there

will be opportunities for family and significant others to meet with staff, with the consumers consent, to discuss their observations and concerns.

Crisis Intervention/Crisis Stabilization

There may be times when a consumer is in a situational crisis and needs urgent assistance. The FT expectation is that consumers will utilize the program to communicate concerns prior to the end of the day. The FT therapists will assist in addressing concerns and in identifying a plan for management. If a crisis occurs outside of program hours, the consumer may request assistance through Emergency Services.

After hours, the consumer can call Woodburn Center Emergency Services. Emergency Services at Woodburn are available when IRS staff or Emergency Services at the Mount Vernon or Northwest Centers cannot be accessed.


Recommends Resource Shifts
Integrated Referral and Transition Team
Placements, Problem Solving, Monitoring
Mental Health Recovery, Employment and Rehabilitation Services
Drop-in Center
Vocational Services
Community Readiness and Support
Vocational Services
Drop-in Center
Psycho-Social Rehab
Vocational Services
Drop-in Center
Employ-ment Services
Vocational Services
Drop-in Center
Focused Treatment
Vocational Services
Drop-in Center
Intensive Recovery Services
Vocational Services
Drop-in Center
Consumers will move among these modules based on need, consumer choice and availability.
Community Involvement Partnership Council
Input on all Adult MH Programs